



## **DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN**

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### **MISSOURI MEDICAID PROGRAM CHANGES**

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#### **BENEFIT COVERAGE**

Senate Bill 539 was passed by the 93rd General Assembly and becomes effective August 28, 2005. Changes in Medicaid Program benefits are effective for dates of service on or after September 1, 2005. The bill eliminated certain optional Medicaid services for individuals age 21 and over that are eligible for Medicaid under one of the following categories of assistance:

<u>ME CODE</u>	<u>DESCRIPTION</u>
01	Old Age Assistance (OAA)
04	Permanently and Totally Disabled (APTD)
05	Medical Assistance for Families – Adult (ADC-AD)
10	Vietnamese or Other Refugees (VIET)
11	Medical Assistance – Old Age (MA-OAA)
13	Medical Assistance – Permanently and Totally Disabled (MA-PTD)
19	Cuban Refugee
21	Haitian Refugee
24	Russian Jew
26	Ethiopian Refugee
83	Presumptive Eligibility – Breast or Cervical Cancer Treatment (BCCT)
84	Regular Benefit – Breast or Cervical Cancer Treatment (BCCT)

**NOTE:**

- Medicaid recipients residing in nursing homes will be able to use their surplus to pay for federally mandated medically necessary services. This may be done by adjudicating claims through the Medicaid claims processing system to ensure best price, quality, and program integrity.
- Medicaid recipients receiving home health services will receive all federally mandated medically necessary services.
- Medicaid/MC+ children and those in the assistance categories for pregnant women or blind recipients will not be affected by these changes.

**COMPREHENSIVE DAY REHABILITATION**

The Comprehensive Day Rehabilitation program has been eliminated for adults. Provider type 76 (Comprehensive Rehabilitation) will no longer be eligible to provide services to adults receiving a limited benefit package.

**COPAYMENT REQUIREMENTS**

Beginning September 1, 2005, recipients eligible to receive Missouri Medicaid services under certain program areas shall be required to pay a small portion of the costs of the services. Provider types required to collect a copay and the copayment amount are listed below.

**Hospital and Physician-Related Providers**

The hospital and physician-related provider types affected by the copayment requirements and the copayment amounts are listed in the following chart. Each provider providing treatment for each date of service on which the recipient receives services shall charge the copayment.

TYPE OF PROVIDER	COPAY AMOUNT
Inpatient Hospital (Prov. Type 01) Copayment will be applied to the first date of admission, except for emergency or transfer inpatient hospital admissions	\$10.00
Outpatient Hospital (Prov. Type 01)	\$3.00
Case Management (Prov. Type 18, Specialty A7)	\$1.00
Physician, M.D. (Prov. Type 20)	\$1.00
Physician, D.O. (Prov. Type 24)	\$1.00
Nurse Midwife (Prov. Type 25)	\$1.00
Nurse Practitioner (Prov. Type 42)	\$1.00
Psychologist/Psychologist (Prov. Type 49, Specialty 45)	\$2.00
Independent Clinic/FQHC (Prov. Type 50, Specialty C8)	\$2.00
Independent Clinic (Prov. Type 50)	\$0.50
Public Health Dept Clinic (Prov. Type 51)	\$0.50
Teaching Institution Department (Prov. Type 54)	\$0.50
Teaching Institution (Prov. Type 55)	\$0.50
Rural Health Clinic (Prov. Type 59)	\$2.00
Independent Laboratory (Provider Type 70)	\$1.00
Independent X-ray Service (Provider Type 71)	\$1.00
CRNA (Provider Type 91)	\$0.50

## Additional Copayment Requirements

Adults receiving a limited benefit package shall continue to be required to pay a small portion of the costs of the services provided through the following programs:

- Dental (Provider Types 40 and 74) – related to trauma or the treatment of a disease/medical condition
- Optical (Provider Types 31, 32 and 53) – related to trauma or the treatment of a disease/medical condition and one eye exam every two years
- Podiatry (Provider Types 30 and 36)

Copayment amounts charged for these programs shall be based on the reimbursement amount per date of service or item as listed on the following schedule:

Medicaid Payment for Each Item or Date of Service	Recipient Copayment Amount
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

## Exemptions to the Copayment Requirements

The following exemptions apply to the Medicaid copayment requirement:

- Services provided to recipients under nineteen (19) years of age; or recipients receiving Medicaid under the following categories of assistance: ME Codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87, and 88;
- Services provided to recipients residing within a skilled nursing home, an intermediate care nursing home, a residential care home, an adult boarding home or a psychiatric hospital; or recipients receiving Medicaid under the following categories of assistance: ME Codes 23 and 41;
- Services provided to recipients who have both Medicare and Medicaid if Medicare covers the service and provides payment for it; or recipients receiving Medicaid under the following category of assistance: ME Code 55;
- Emergency or transfer inpatient hospital admission;
- Emergency services provided in an outpatient clinic or emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the patient's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part;
- Certain therapy services (physical therapy, chemotherapy, radiation therapy, psychotherapy and chronic renal dialysis) except when provided as an inpatient hospital service;

- Services provided to pregnant women who are receiving Medicaid under the following categories of assistance only: ME Codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to foster care recipients who are receiving Medicaid under the following categories of assistance: ME Codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Services identified as medically necessary through an Early Periodic Screening, Diagnostic and Treatment (EPSDT) screen;
- Services provided to persons receiving Medicaid under a category of assistance for the blind: ME Codes 02, 03, 12 and 15;
- Services provided to MC+ Managed Care enrollees;
- Mental Health services provided by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;
- Family planning services;
- Medicaid Waiver services;
- Hospice services; and
- Personal Care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility.

### **Provider Responsibility**

Providers are responsible for collecting the copayment amounts from the Medicaid recipient. The Medicaid Program shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient. The provider shall collect a copayment from a recipient at the time each service is provided or at a later date. Providers of services subject to a copayment requirement may not deny or reduce services otherwise eligible for Medicaid benefits on the basis of the recipient's inability to pay the due copayment amount when charged.

A recipient's inability to pay a required copayment amount, as due and charged when a service is delivered, in no way shall extinguish the recipient's liability to pay the due amount or prevent a provider from attempting to collect a copayment.

### **Uncollected Copayment Debt**

If it is the routine business practice of a provider to discontinue future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice. However, a provider shall give a Medicaid recipient a reasonable opportunity to pay an uncollected copayment. If a provider is not willing to provide services to a Medicaid recipient with uncollected copayment, the provider must give the recipient advanced notice and a reasonable opportunity to arrange care with a different provider before services can be discontinued.

## **Provider Participation Privileges**

Participation privileges in the Medicaid program shall be limited to providers who accept, as payment in full, the amounts paid by the state agency plus any copayment amount required of the recipient. Providers of services in the program areas affected by the copayment requirement must charge copayment as specified at the time the service is provided to retain their participation privileges in the Missouri Medicaid program. Providers must maintain records of copayment amounts for five (5) years and must make those records available to the Department of Social Services upon request.

## **DENTAL SERVICES**

Effective for dates of service on or after September 1, 2005, Missouri Medicaid will **only** consider dental services for adults (except individuals under a category of assistance for pregnant women or the blind or nursing facility residents) if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a disease/medical condition without which the health of the individual would be adversely affected. Dental services for children ages 20 and under remain unchanged.

### **Prior Authorized Adult Dental Services**

The following prior authorization guidelines will apply to adult dental care related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a disease/medical condition without which the health of the individual would be adversely affected:

1. A Prior Authorization (PA) Request form must be completed and mailed to Infocrossing at the address below.
2. The dental care must be related to trauma or treatment of a disease/medical condition.
3. Dental procedure code (including diagnosis) must be prior authorized if services are related to the treatment of a traumatic injury or a medical condition.
4. The dental provider performing the service must submit the PA Request.
5. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
6. A prescription or referral that documents the need for dental care due to a traumatic injury or for treatment due to a medical condition must be included.
7. Prior authorization does not guarantee payment if the recipient is or becomes enrolled in MC+ Managed Care or is not otherwise eligible. MC+ Managed Care health plans continue to be responsible for dental services related to trauma and disease/medical condition.
8. Payment will not be made for services initiated before the approval date on the PA Request form or after the authorization deadline.
9. For services to continue after the expiration date of an existing PA Request, a new PA Request must be completed and mailed.

## **Dental On-Line Prior Authorization Request Form And Instructions**

For access to a blank PA Request form, instructions and guidelines, dental providers should refer to Section 8 of the Dental Provider Manual on the Internet at [www.dss.missouri.gov/dms](http://www.dss.missouri.gov/dms). The on-line PA Request form can be printed and completed by hand or the form can be completed in Adobe and then printed. To enter information into a field, either click on the field or tab to the field and complete the information. When all the fields are complete, print the PA Request form and send with all supporting documentation to the address listed below:

Infocrossing Healthcare Services  
P.O. Box 5700  
Jefferson City, Missouri 65102

With the exception of x-rays, dental molds, and photos, documentation submitted with the PA Request will not be returned. Providers should retain a copy of the original PA Request and any supporting documentation submitted for processing. The dental program consultant will review the request. A Missouri Medicaid Authorization Determination will be returned to the provider with any stipulations for approval or reason for denial.

If approved, services may not exceed the frequency, duration or scope approved by the dental consultant. If the dental service or item requested is to be manually priced, the consultant enters the allowed amount on the Missouri Medicaid Authorization Determination. The provider should keep the approved Missouri Medicaid Authorization Determination for their files; do not return it with the claim. After the authorized service or item is provided, the claim form must be completed and submitted in the usual manner.

If the request for authorization of adult dental services is denied, the provider will receive a Missouri Medicaid Authorization Determination. The recipient is notified by letter each time a request for prior authorization is denied.

## **Dental Care Prior Authorization Request Guidelines**

Dental services may be prior authorized if dental care is related to:

- Traumatic injury to the jaw, mouth, teeth, or, other contiguous (adjoining) sites (above the neck)
- Medical condition related to or for a:
  - Transplant patient
  - Chemo/radiation therapy patient
  - Systemic diseases
    - AIDS
    - Other autoimmune diseases
  - Uncontrolled diabetics
  - Paraplegic
  - Quadriplegic
  - Any other medical condition if left untreated, the dental problems would adversely affect the health of the individual resulting in a higher level of care

Dental services (unless associated with medical conditions listed above) will not be approved for Periodontal disease or other diseases of the gums.

## **Emergency Adult Dental Services**

Adult dental services provided in emergency situations will be considered on a case-by-case basis. Payment for emergency adult dental services when prior authorization has not been obtained will require the submission of a completed prior authorization request with attached documentation, including a medical necessity form. This documentation must thoroughly explain the emergency nature of the services provided. The claim cannot be billed until the approved [Missouri Medicaid Authorization Determination](#) has been received by the provider.

## **Custom-Made Dental Items**

Custom-made items, including full and partial dentures ordered or fabricated prior to September 1, 2005 and placement occurs on or after September 1, 2005, are covered under the custom-made item policy. Refer to section 13.10 of the Dental Manual for further information on the custom-made item policy.

## **Dental Program Restrictions**

A prior authorization approves the medical necessity of the adult dental service and does not guarantee payment. Claim information must still be complete and correct, and the recipient must be eligible at the time the service is rendered or an item is delivered. Program restrictions such as age, category of assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible recipients are not reimbursed.

## **DIABETES SELF-MANAGEMENT TRAINING SERVICES**

Effective September 1, 2005 the following procedure codes will no longer be covered for adults receiving a limited benefit package:

99205U9 (Initial Assessment–Comprehensive Diabetes Education)

G0108 (Diabetes Education–Subsequent Visit)

G0109 (Diabetes Education–Group Subsequent (No more than 8 persons))

## **DURABLE MEDICAL EQUIPMENT (DME)**

The following items of DME are not covered for adults receiving a limited benefit package:

- apnea monitors
- artificial larynx and related items
- augmentative communication devices
- canes and crutches
- commodes, bed pans and urinals
- CPAP devices
- decubitus care equipment
- hospital beds and side rails
- humidifiers
- BiPAP machines
- IPPB machines
- Nebulizers

- orthotics
- patient lifts and trapeze
- scooters
- suction pumps
- total parenteral nutrition mix, supplies and equipment
- walkers
- wheelchair accessories, labor and repair codes

### **DME Under a Home Health Plan of Care**

Adults under a home health plan of care remain eligible to receive the above listed non-covered items of DME. However, the item must be included in the home health plan of care, and must meet all other requirements of the DME Program. The DME provider must have in the patient's file a copy of the Home Health Plan of Care signed by the physician. Prior authorization requests and claims for reimbursement of these items must include the certification dates from the home health plan of care. Claims will only be reimbursed when a home health program claim has been processed for the certification period indicated on the DME claim.

### **Custom-Made DME**

Custom-made items of durable medical equipment ordered or fabricated prior to September 1, 2005 and placement occurs on or after September 1, 2005, are covered under the custom-made item policy. Refer to section 13.15 of the DME Manual for further information on the custom-made item policy.

### **HEARING AID PROGRAM**

All services covered under the Hearing Aid Program will no longer be covered for adults in a reduced benefits category of assistance.

### **HOME HEALTH**

Physical, occupational and speech therapy services provided through the Home Health Program are not covered.

Individuals in the reduced benefit category of assistance who receive home health services will be eligible for the otherwise non-covered DME and supplies when the item is included in the home health plan of care and provided during the home health certification period. The home health agency must coordinate with the DME provider to ensure provision of DME prescribed. Providers of DME will be required to have a copy of the home health plan of care prior to billing Missouri Medicaid. Claims for otherwise non-covered DME submitted by a DME Provider will not be reimbursed until a Home Health claim has been processed by Missouri Medicaid for the recipient. Reference the information above regarding benefits under the DME Program.

### **OPTICAL PROGRAM**

Eye examinations for refractive error will be limited to one exam every two years for adults with a limited Medicaid benefit package and services related to trauma or treatment of a disease/medical condition.



## **OUTPATIENT THERAPY**

Effective September 1, 2005, speech, occupational or physical therapy associated with rehabilitation services will no longer be a covered Medicaid service for adults receiving a limited benefit package. Provider type 57 (Rehabilitation Centers) will no longer be eligible to provide services to adults receiving a limited benefit package.

Physical, occupational and speech therapy services are no longer covered under the Home Health Program.

The codes, listed below, when provided in the outpatient hospital setting will no longer be covered.

9-92506	Evaluation of speech, language, voice, communication, auditory processing and/or aural rehab status
9-92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
9-92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more
9-97001	Physical therapy evaluation
9-97002	Physical therapy re-evaluation
9-97003	Occupation therapy evaluation
9-97004	Occupation therapy evaluation
9-97014	Physical medicine treatment to one area electrical stimulation (unattended)
9-97016	Physical medicine treatment to one-area vasopneumatic devices
9-97018	Physical medicine treatment to one area paraffin bath
9-97020	Physical medicine treatment to one area microwave
9-97022	Physical medicine treatment to one area whirlpool
9-97024	Physical medicine treatment to one area diathermy
9-97026	Physical medicine treatment to one area infrared
9-97028	Physical medicine treatment to one area ultraviolet
9-97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
9-97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
9-97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
9-97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
9-97036	Hubbard tank each 15 minutes
9-97039	Unlisted modality
9-97110	Therapeutic procedure 1/more areas, each 15 min; to develop strength/endurance/flexibility etc.
9-97112	Therapeutic procedure 1/more areas, each 15 min; neuromuscular reeducation of movement, balance, etc.
9-97113	Therapeutic procedure one or more areas each 15 minutes; aquatic therapy w/therapeutic exercises
9-97116	Therapeutic procedure 1/more areas, each 15 min; gait training (includes stair climbing)
9-97124	Therapeutic procedure 1/more areas, each 15 min.; massage, include effleurage, petrissage/tapotement

9-97139	Therapeutic procedure one or more areas, each 15 min; unlisted therapeutic procedure (specify)
9-97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual trac...)
9-97504	Orthotics fitting and training, upper and/or lower extremities, each 15 min.
9-97520	Prosthetic training upper &/or lower extremities, each 15 min
9-97530	Therapeutic activities direct patient contact by the provider, each 15 min
9-97535	Self care/home management training (etc.) direct one on one contact by provider, each 15 min
9-97602	Removal of devitalized tissue from wound/non-selective debridement, w/o anesthesia, including topical
9-97703	Checkout for orthotic/prosthetic use established patient, each 15 min
9-97750	Physical performance test/measurement (e.g. musculoskeletal, functional capacity), each 15 min

### **PHYSICIAN REHABILITATION SERVICES**

The following physician rehabilitation services will no longer be covered effective September 1, 2005 for adults receiving a limited benefit package:

92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehab status
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97012	Physical medicine treatment to one area traction, mechanical
97014	Physical medicine treatment to one area electrical stimulation, unattended
97016	Physical medicine treatment to one area, vasopneumatic devices
97018	Physical medicine treatment to one area paraffin bath
97020	Physical medicine treatment to one area microwave
97022	Physical medicine treatment to one area whirlpool
97024	Physical medicine treatment to one area diathermy
97026	Physical medicine treatment to one area infrared
97028	Physical medicine treatment to one area ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation, manual, each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality
97110	Therapeutic procedure 1/more areas, each 15 minutes; to develop strength/endurance/flexibility etc.
97112	Therapeutic procedure 1/more areas, each 15 minutes; neuromuscular reeducation of movement, balance, etc.
97113	Therapeutic procedure 1/more areas, each 15 minutes; aquatic therapy w/therapeutic exercises
97116	Therapeutic procedure 1/more areas, each 15 minutes; gait training, includes stair climbing

97124	Therapeutic procedure 1/more areas, each 15 minutes; massage, include effleurage, petrissage/tapotement
97139	Therapeutic procedure 1/more areas, each 15 minutes; unlisted therapeutic procedure
97140	Manual therapy techniques
97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97520	Prosthetic training upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities direct patient contact by the provider, each 15 minutes
97535	Self care/home management training, etc., direct one on one contact by provider, each 15 minutes
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	Physical performance test/measurement, each 15 minutes
97755	Assistive technology assess
97799	Unlisted physical medicine/rehabilitation service or procedure

### **PODIATRY SERVICES**

The following podiatry services have been eliminated for adults receiving a limited benefit package:

11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method(s); one to five
11721	Debridement of nail(s) by any method(s); six or more
11750	Excision of nail and nail matrix, partial or complete
29540	Strapping of ankle and/or foot

### **PRIOR AUTHORIZATION OF SERVICES**

Any Prior Authorization for individuals receiving limited benefit coverage that has been approved for an eliminated service beyond August 31, 2005 will be terminated effective September 1, 2005.

**Provider Bulletins** are available on the DMS Website at <http://www.dss.mo.gov/dms/pages/bulletins.htm>. Bulletins will remain on the Published Bulletin site only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin site.

**Missouri Medicaid News:** Providers and other interested parties are urged to go to the DMS Website at <http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm> to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

**MC+ Managed Care:** The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

**Provider Communications Hotline**  
**573-751-2896**